CMS Manual System	Department of Health & Human Services DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 171	Date: NOVEMBER 9, 2006
	Change Request 5271

This CR is being re-communicated to change the effective and implementation dates for non-systems changes to December 9, 2006 and for system changes the effective date is January 1, 2007 and the implementation date is January 2, 2007. All other material remains the same.

SUBJECT: Outpatient Therapy Cap Clarifications

I. SUMMARY OF CHANGES: Clarifies contractor instructions related to therapy cap exception process. The heading 3.4.1.2.1 is replaced by 3.4.1.1.1, and moved to the beginning of the section on therapy. These policies should be implemented as soon as possible.

CLARIFICATION
EFFECTIVE DATE*: **December 9, 2006, for non-systems changes, January 1, 2007, for systems changes**
IMPLEMENTATION DATE: December 9, 2006, for non-systems changes, January 2, 2007, for systems changes

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/Table of Contents
N	3.4.1.1.1/Exception From the Uniform Dollar Limitation (“Therapy Cap”)
D	3.4.1.2.1/Eception From the Uniform Dollar Limitation (“Therapy Cap”)
R	11.1.3.9/Prepay Complex Review Workload and Cost (Activity Code 21221)

III. FUNDING:

No additional funding will be provided by CMS; cntractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-08	Transmittal: 171	Date: November 9, 2006	Change Request 5271

This CR is being re-communicated to change the effective and implementation dates for non-systems changes to December 9, 2006 and for system changes the effective date is January 1, 2007 and the implementation date is January 2, 2007. All other material remains the same.

SUBJECT: Outpatient Therapy Cap Exceptions Clarifications

I. GENERAL INFORMATION

A. Background: Financial limitations on Medicare covered therapy services (therapy caps) were initiated by the Balanced Budget Act of 1997 and were implemented in 1999 and for a short time in 2003. Congress placed moratoria on the limits for 2004 and 2005. The moratoria are no longer in place, and caps were implemented on January 1, 2006. Congress has provided that exceptions to this dollar limitation may be made when provision of additional therapy services is determined to be medically necessary.

Cap amounts change annually and have recently been computed for 2007 and the amount of the caps has been added to this CR. Therefore, the language relative to the cap exceptions, which does not require systems changes, shall be effective and implemented 30 days after issuance. The language in this CR relative to the therapy cap update, and that which does require systems changes, shall be effective and implemented January 1, 2007, as required by statute and shall not be made public until November 1, 2006.

B. Policy: Section 1833(g)(5) of the Social Security Act provides that, for services provided during calendar year 2006, contractors shall, at the request of the individual enrolled under the Part B benefit or a person acting on behalf of that individual, grant an exception to the therapy cap in certain circumstances. Claims for services above the cap for which an exception is not granted will be denied as a benefit category denial, and the beneficiary will be liable. Providers do not need to issue an ABN for these benefit category denials.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5271.1	The contractor shall grant exceptions for any number of medically necessary services that meet the outpatient therapy automatic process exception criteria, if the beneficiary meets the conditions described in IOM Pub. 100-04, chapter 5, for 2006.	X	X	X						A/B MAC
5271.2	The contractor shall utilize clinical judgment in approving or disapproving requests for additional treatment days in the exceptional circumstance where a provider fails to submit all required documentation with the exception request in 2006.	X	X	X						A/B MAC
5271.3	The contractor shall grant an exception to the therapy cap, by way of approving any number of additional therapy treatment days, when those additional treatment days are deemed medically necessary based on documentation submitted by the provider in 2006.	X	X	X						A/B MAC
5271.4	The contractor shall grant an exception to the therapy cap, approving the number of treatment days requested by the provider/supplier/beneficiary, not to exceed 15 future treatment days, if the contractor does not make a decision within 10 business days of receipt of any request and appropriate documentation in 2006.	X	X	X						A/B MAC
5271.5	When reviewing claims for services excepted from therapy caps where there is evidence of potential provider fraud, the contractor shall follow the instructions in 100-08, chapter 4, on how to treat the claim in 2006.	X	X	X						A/B MAC
5271.6	When reviewing claims for services excepted from therapy caps the contractor shall deny the claim where there is evidence of misrepresentation of facts presented to the contractor by that provider in 2006.	X	X	X						A/B MAC

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5271.7	When reviewing claims for services excepted from therapy caps due to a pattern of aberrant billing the contractor shall deny the services that are not reasonable and necessary.	X	X	X						A/B MAC
5271.8	When replying to a request for exception, the contractor must reply as soon as practicable in 2006.	X	X	X						A/B MAC
5271.9	When replying to a request for exception, the contractor shall send the letter in Pub. 100-08, chapter 3, most appropriate to the circumstance in 2006.	X	X	X						A/B MAC
5271.10	The contractor shall develop a mechanism to track workload associated with the Therapy Cap process in 2006.	X	X	X						A/B MAC
5271.11	The contractor shall develop a mechanism to track costs associated with the Therapy Cap process in 2006.	X	X	X						A/B MAC
5271.12	For CY 2006, carriers and fiscal intermediaries shall report the therapy cap costs and workload on a monthly basis in activity code 27021 (not 21221). Note that if cap exceptions are extended beyond 2006, further instructions will be sent.	X	X	X						A/B MAC
5271.13	Contractors shall continue to report automatic and manual process exceptions separately on a monthly basis using the format and fields in the attachments to JSM/TDL-06427, 05-01-06 in 2006.	X	X	X						A/B MAC
5271.14	Contractors shall continue to enforce LCDs, since the presence of a KX does not supersede an LCD in 2006.	X	X	X						A/B MAC

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5271.15	Contractors shall note that the MSN messages in Pub. 100-04, chapter 21, have been modified to match the correct MSN messages in chapter 5.	X	X	X						A/B MAC
5271.15.1	Contractors shall modify MSN messages to match the MSN language in chapter 5, section 10.2D.	X	X	X						A/B MAC
5271.15.2	Modified MSN messages, as described in Pub. 100-04, chapter 5, section 10.2D, shall be issued on all claims for outpatient therapy services until this instruction is changed.	X	X	X						A/B MAC
5271.16	Contractors shall note that the total amount paid for outpatient therapy services before the cap is reached, including deductible and coinsurance paid by the beneficiary, is $1740 for calendar year 2006.	X	X	X						A/B MAC
5271.17	Contractors shall note that the total amount paid for outpatient therapy services before the cap is reached, including deductible and coinsurance paid by the beneficiary, is $1780 for calendar year 2007.	X	X	X						A/B MAC
5271.17.1	CWF shall change the dollar amount for the limitation on outpatient physical therapy and speech-language pathology services combined to $1780 for dates of service from January 1, 2007 through December 31, 2007.	X	X	X		X			X	A/B MAC
5271.17.2	CWF shall change the dollar amount for the limitation on outpatient occupational services combined to $1780 for dates of service from January 1, 2007 through December 31, 2007.	X	X	X		X			X	A/B MAC
5271.18	Contractor shall, in future articles and publications that reference exceptions to therapy caps in 2006, refer to the automatic process and the manual process for exception as opposed to automatic exceptions and manual	X	X	X						A/B MAC

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	exceptions.									
5271.19	Contractors shall follow the instructions in Pub. 100-04, chapter 5, for allowing outpatient therapy cap exceptions when the same patient has two conditions or complexities in the same year, one of which qualifies the beneficiary for use of the automatic exception process in 2006.	X	X	X						A/B MAC
5271.20	Contractors shall allow automatic process exceptions when complexities occur in combination with conditions that may or may not be on the list in Pub. 100-04, chapter 5, in 2006.	X	X	X						A/B MAC
5271.21	Contractors shall update the list of exceptions in 2006 according to the changes provided in this transmittal. Note that contractors may expand, but not remove ICD-9s from the list if their manual process exception decisions lead them to believe further exceptions should be allowed.	X	X	X						A/B MAC
5271.22	Contractors shall allow automatic process exceptions when medically necessary services are provided for two or more separate, billable, conditions in the same calendar year in 2006.	X	X	X						A/B MAC
5271.23	Contractors shall not utilize the KX modifier in data analysis as the sole indicator of services that DO exceed caps in 2006. For all claims, but especially for intermediary claims, there may be services with appropriately used KX modifiers that do not represent services that exceed the cap.	X	X	X						A/B MAC
5271.24	Contractors shall utilize consistently the new definitions and examples provided in this transmittal for Pub. 100-02, chapter 15.	X	X	X						A/B MAC

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5271.25	When a patient is being treated under the care of two physicians for separate conditions, contractors shall accept as appropriate documentation either a combined plan of care certified by one of the physicians/NPPs or two separate plans of care certified by separate physicians/NPPs.	X	X	X						A/B MAC
5271.26	Contractors shall not require the additional documentation that is encouraged but not required in Pub. 100-02, chapter 15.	X	X	X						A/B MAC
5271.26.1	In the event provider/suppliers fail to submit all requested documentation for the manual process therapy cap exception in 2006, contractors shall make determinations using clinical judgment based on all documentation received before the 10th day after submission of the request.	X	X	X						A/B MAC
5271.27	Contractors shall interpret a referral or an order or a plan of care dated after an evaluation as certification of the plan to evaluate the patient when only an evaluation was performed. It is not required that a plan, order or referral be written prior to evaluation.	X	X	X						A/B MAC
5271.28	Contractors shall not deny payment for re-evaluation only because an evaluation or re-evaluation was recently done. For example: 1) re-evaluation is covered and payable if documentation supports the need for re-evaluation; 2) re-evaluation may be appropriate prior to planned discharge for the purposes of a) determining whether goals have been met, or b) to provide further information, beyond that required to be included in the discharge summary, for the use of the physician or the treatment site at which treatment will be continued.	X	X	X						A/B MAC

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5271.29	Contractors shall, on pre or postpay medical review, require Progress Reports to be written by clinicians once during each Progress Report Period.	X	X	X						A/B MAC
5271.29.1	When required elements of the Progress Report are written into the Treatment Notes or in a Plan of Care, the contractors shall accept it as fulfilling the requirement for a Progress Report; a separate Progress Report shall not be required.	X	X	X						A/B MAC
5271.29.2	When therapists are not providing all of the treatment, contractors shall, if performing pre or postpay medical review, require a clinician's active participation in treatment at least during each Progress Report Period, except as noted in 5271.29.3.	X	X	X						A/B MAC
5271.29.3	When a clinician has not actively participated in treatment during the Progress Report Period due to the patient's unexpected absence, the contractor shall, if performing pre or postpay review, make a clinical judgment based on each individual case whether continued treatment after the Progress Reporting Period is medically necessary.	X	X	X						A/B MAC
5271.29.3.1	When a clinician has not actively participated in treatment during the Progress Report Period due to an unanticipated and unusual occurrence, the contractor shall, if performing pre or postpay review, make a clinical judgment based on each individual case whether continued treatment after the Progress Reporting Period is medically necessary.	X	X	X						A/B MAC
5271.29.3.2	When a clinician has not actively participated in treatment during the Progress Report Period, the contractor shall, if performing prepay or postpay medical review, include in their consideration of medical necessity whether documentation indicates the clinicians active guidance of treatment during the reporting	X	X	X						A/B MAC

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	period.									
5271.29.3.3	When a clinician has not actively participated in treatment during the reporting period, the contractor shall, if performing prepay or postpay medical review, include in their consideration of medical necessity whether documentation indicates that continued services beyond the reporting period are likely to be as safe and appropriate for the beneficiary as the alternative of discontinuing treatment	X	X	X						A/B MAC
5271.30	Contractors shall require, if performing pre or postpay medical review of documentation, that when the services incident to a physician's services are provided by qualified personnel who are not therapists, the ordering or supervising physician/NPP must personally provide at least one treatment session during each Progress Report Period and sign the Progress Report.	X	X	X						A/B MAC
5271.31	CWF shall exclude from the financial limitation on outpatient therapy described in Pub. 100-04, chapter 5, section 10.2 claims having the all the following conditions: 1. Dates of services from January 1, 2006 through December 31, 2007; 2. Modifier of GN, GO, or GP; and 3. Place of service code equals 22 (outpatient hospital) or 23 (emergency room-hospital).								X	
5271.32	CWF shall apply the outpatient therapy financial limitation described in Pub. 100-04, chapter 5, section 10.2, in the order of date received.								X	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5271.33	Contractors shall deny claims for outpatient therapy services exceeding the financial limits described in Pub. 100-04, chapter 5 section 10.2 as indicated by CWF and as appropriate according to Medicare policy.	X	X	X						A/B MAC
5271.34	Contractors shall modify Medicare Summary Notices (MSNs) 17.13, 17.18, and 17.19 such that when the calendar year is 2007, the ($) limit is $1780 effective January 1, 2007.	X	X	X						A/B MAC
5271.35	Contractors shall change any reference in their educational materials to reflect therapy limits for CY 2007 as $1780 for physical therapy and speech-language pathology combined and $1780 for occupational therapy.	X	X	X						A/B MAC
5271.36	The CWF shall display the therapy cap amount applied per beneficiary on all CWF inquiry screens (HIMR, HIQA, HUQA, HIQH, ELGA, ELGB, and ELGH)								X	
5271.37	In processing claims where Medicare is the secondary payer, the shared system takes the lowest secondary payment amount from MSPPAY and sends this amount to CWF as the amount applied to therapy limits.					X	X			

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5271.38	A provider education article related to this instruction will be available at www.cms.hhs.gov/MLNMattersArticles shortly after the CR is released. You will receive	X	X	X						A/B MAC

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: **December 9, 2006, for non-systems changes, January 1, 2007 for systems changes**	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating**

Implementation Date: December 9, 2006, for non-systems changes, January 2, 2007 for systems changes **Pre-Implementation Contact(s):** Exceptions Process and Medical Review: Dan Schwartz (daniel.schwartz@cms.hhs.gov) or Kim Spalding (kimberly.spalding@cms.hhs.gov); Clinical and Documentation Issues: Dr. Dorothy Shannon (dorothy.shannon@cms.hhs.gov); Claims Processing: Claudette Sikora (claudette.sikora@cms.hhs.gov) or Wil Gehne (Wilfred.gehne@cms.hhs.gov) Appeals: David Danek (david.danek@cms.hhs.gov) **Post-Implementation Contact(s):** Regional offices	**budgets.**

***Unless otherwise specified, the effective date is the date of service.**

Medicare Program Integrity Manual

Chapter 3 - Verifying Potential Errors and Taking Corrective Actions

Table of Contents
(Rev. 171, 11-09-06)

3.4.1.1.1 - Exception From the Uniform Dollar Limitation ("Therapy Cap")

(Rev. 171; Issued: 11-09-06; Effective: 12-09-06; Implementation: 12-09-06)

Section 1833(g)(5) of the *Social Security Act* provides that, for services provided during calendar year 2006, contractors shall, at the request of the individual enrolled under the Part B benefit or a person acting on behalf of that individual, grant an exception to the therapy cap in certain circumstances.

Automatic Exceptions from Therapy Caps

The contractor shall presume the beneficiary to be excepted from the therapy cap without submission of request for exception or supporting documentation if:

- The beneficiary meets specific conditions listed in CMS IOM Pub. 100-04 chapter 5 for exception from the therapy cap, or

- The beneficiary meets specific criteria for exception, in addition to those listed in CMS IOM Pub. 100-4, chapter 5, where the contractor believes, based on the strongest evidence available, that those beneficiaries will require additional therapy treatment days beyond those payable under the therapy cap.

When the contractor develops therapy cap exception criteria, in addition to those described in CMS IOM Pub. 100-4, *chapter* 5, those criteria must be published, in the form of an article, on the contractor's Web site. Documentation requirements are in CMS IOM Pub. 100-02, chapter 15, section 230.3

Initial Request for Exception from Therapy Caps

For beneficiaries who the provider believes will require therapy treatment days in excess of those payable under the therapy cap, and who do not meet at least one of the above bulleted criteria for automatic exception, the Medicare contractor shall require the provider to submit a request for a specific number of additional therapy treatment days, not to exceed 15. Separate requests will be required for exception from the occupational therapy cap and from the combined physical therapy/speech language pathology caps.

The contractor shall require that documentation, sufficient to support medical necessity of those additional treatment days, be submitted with the request. The contractor shall require the provider to submit documentation in accordance with CMS IOM Pub. 100-02, chapter 15, section 220.3 and CMS IOM Pub. 100-04, chapter 5, sections 102 and 20 with the request for treatment days in excess of those payable under the therapy cap. Required documentation must include the current evaluation or reevaluation and current plan of care, treatment encounter notes, and interval progress reports sufficient to explain the beneficiary's current functional status and need for continued therapy with the request for therapy treatment days in excess of those payable under the therapy cap.

Contractors shall encourage that most requests for exception from the therapy cap be received before the cap is exceeded. In those exceptional circumstances where a provider does not submit a timely request for exception from the therapy cap, the contractor shall approve any number of treatment days retroactively, if they were medically necessary.

Subsequent Requests for Continued Therapy During the Same Episode of Care

For beneficiaries who the provider believes will require therapy treatment days in excess of those previously approved, the contractor shall require the provider to submit a new request for approval of a specific number of additional future therapy treatment days, not to exceed 15, each time the beneficiary is expected to require more therapy treatment days.

The contractor shall require that documentation sufficient to support medical necessity of those additional treatment days be submitted with the request. Required documentation must include current evaluation or reevaluation and current plan of care, treatment encounter notes, and interval progress reports sufficient to explain the beneficiary's current functional status and need for continued therapy.

Multiple Requests for Exception for the Same Beneficiary

If an initial or subsequent request for exception from the therapy cap is denied, the contractor shall accept another request for exception for that beneficiary only if the beneficiary's condition has significantly changed.

Contractor Response to Requests for Exception From Therapy Caps

Upon receipt of the request for additional therapy treatment days, along with appropriate supporting documentation, the Medicare contractor shall, within 10 business days *of receipt of the request*, make a decision as to whether and how many additional therapy treatment days are medically necessary and notify the provider whether an exception to the cap has been made *as soon as practicable*. In the case where a provider fails to submit required documentation, the contractor shall use clinical judgment in deciding whether to approve or disapprove the request for additional therapy treatment days.

The contractor shall grant an exception to the therapy cap, by way of approving additional therapy treatment days, when those additional treatment days are deemed reasonable and necessary based on documentation submitted by the provider. The contractor may approve fewer than the number of additional therapy treatment days requested by the provider if the contractor believes that the requested number are not medically necessary. The contractor may approve any number of additional treatment days that the contractor determines are medically necessary, based on the documentation provided. The contractor shall make the decision within 10 business days of receipt of request and appropriate documentation, and notify the provider as soon as practicable using the appropriate standard letter (See "Exhibit" below) as to whether an exception to the cap has been made, how many unlimited retroactive treatment days and how many

additional future treatment days *(*not to exceed 15 per discipline*)* are approved. If additional therapy treatment days are not approved, the contractor shall make that decision within 10 business days of receipt of request and appropriate documentation, and notify the provider as soon as practicable using the appropriate standard letter that additional therapy treatment days are disapproved if not found to be medically necessary, that the decision on the exception request is not an initial determination, and therefore does not carry with it administrative appeal rights, and that subsequent claims for additional therapy treatment days which are denied are denied as benefit category denials.

In order to avoid delay in reviewing and processing claims, the contractor is encouraged to develop a process by which requests for exception to the therapy cap may be received and logged by the contractor's medical review department. An expeditious receipt of requests for exception from the therapy cap will lessen the potential for unintentional deeming of services to be medically necessary by exceeding the 10 business day time limit for decisions on requests for exception from the cap.

If the Medicare contractor does not issue a decision within those 10 business days, the contractor shall be deemed to have found the additional services requested to be medically necessary. In these cases, the contractor shall grant an exception to the therapy cap, approving the number of treatment days requested by the provider, not to exceed 15.

If the contractor makes the determination that the requested services are medically necessary, that determination is binding on the contractor in the absence of:

- *potential* fraud; or
- evidence of misrepresentation of facts presented to the contractor, or
- A pattern of aberrant billing by a provider.

Should such evidence of *potential* fraud, misrepresentation, or aberrant billing patterns by a provider be found, claims are subject to medical review regardless of whether the request was approved (either after manual review or 10 days after the request).

Progressive Corrective Action (PCA) and Medical review have a role in the therapy prior authorization exception process. Although the services may meet the criteria for exception from the cap due to condition or complexity, they are still subject to review to determine that the services are otherwise covered and appropriately provided. The exception is granted on the clinician's assertion that there is documentation in the record justifying that the services meet the criteria for reasonable and necessary services. For example, the documentation must accurately represent the facts, and there shall be no evidence of patterns of aberrant billing of the services by the provider/supplier. Services deemed medically necessary are still subject to review related to fraud or abuse. An example of inappropriate use of the process is the routine application for exceptions only after the cap has been exceeded. Also, the routine use of the KX modifier on every claim for a patient that has an excepted condition or complexity, regardless of the impact of the condition on the need for services above the cap, is inappropriate.

Exhibit-Required Letter Format and Contents

NOTE: *You are expected to adhere closely to these templates. However, if you have a unique circumstance you can modify the letter as appropriate, keeping as much of the original language as possible.*

Letter #1-Approved

XXXX
XXXX
XXXX

Date

Submitter Name
Submitter Address

Case Number:
Beneficiary Name:
Medicare Number:

SUBJECT: Request for Exception from the Therapy Cap-Approved

Dear Sir/Madam

We have received your [X/XX/XXXX] therapy cap exception request for the above named beneficiary. Based on the information submitted, we have determined that the beneficiary does meet the medical necessity requirements Medicare has established for granting an exception for a number of treatment days. We are granting exceptions to the cap for an additional [insert number] treatment days subject to the terms and conditions below.

This decision does not provide assurance that the beneficiary meets Medicare eligibility requirements nor does it assure that any other Medicare requirements (Medicare Secondary Payer, etc.) have been met. Only upon submission of a complete claim can the [Fiscal Intermediary/Payer] make a full and complete determination.

To ensure proper processing of the claim for these services append the KX modifier to your claim or it will deny. Do not append the modifier to claims not excepted by this letter or to services which are no longer medically necessary.

Also, this decision does not extend to the price Medicare will allow for the service(s). Payment amounts are determined upon receipt of the claim.

This therapy exception decision is valid for [XX] additional treatment days over the cap. Beneficiaries who require therapy are subject to rapid changes in medical condition. These changes may obviate the need for a particular service because the beneficiary's condition either improved or deteriorated. For this reason, if the condition of the patient changes and additional therapy is no longer required, you should not use the KX modifier nor expect payment from Medicare for these services.

We reserve the right to review claims on a pre-or postpayment basis, and may deny claims and take appropriate action when our approval was made based on fraud, misrepresentation, or we discover you are engaged in a pattern of aberrant billing.

For additional information, please see our Web site at www. ____.com

Sincerely,

[Insert Name and/or title]
Medical Review

Letter #2-Negative Decision-Medical Necessity

XXXX
XXXX
XXXX

Date

Submitter Name
Submitter Address

Case Number:
Beneficiary Name:
Medicare Number:

SUBJECT: Request for Exception from the Therapy Cap

Dear Sir/Madam

We have received your [X/XX/XXXX] therapy cap exception request for the above named beneficiary. Based on the information submitted, we have determined that the beneficiary does not meet the medical necessity requirements Medicare has established for granting an exception for these services for the following reasons:

Example: All requests for information must include information which documents the medical condition of the patient that necessitates additional therapy treatment days that

will cause a beneficiary to exceed the cap. In our judgment, the documentation you provided is insufficient to support granting an exception.

This decision is not appealable. Medicare may not make payment for therapy services that exceed the current financial limitation. Such services are considered outside the scope of Medicare coverage, and the beneficiary may be charged for the services when an exception from the cap is not pre-approved. No advance beneficiary notice need be issued.

You may still submit a claim for these services expected to exceed the cap, but you must not append the KX modifier to these services. If the service(s) exceed(s) the cap, the claim will be denied.

If the condition of the patient changes and additional therapy is required, you may submit a new request.

For additional information, please see our Web site at www. ____.com

Sincerely,

[Insert Name and/or title]
Medical Review

Letter #3-Denied-Insufficient Documentation
XXXX
XXXX
XXXX

Date

Submitter Name
Submitter Address

Case Number:
Beneficiary Name:
Medicare Number:

SUBJECT: Request for Exception from the Therapy Cap

Dear Sir/Madam

We have received your [X/XX/XXXX] therapy cap exception request for the above named beneficiary. Based on the information submitted, we have determined that the

beneficiary does not meet the medical necessity requirements Medicare has established for granting an exception for these services for the following reasons:

Example: All requests for information must include a current plan of care, a narrative explanation/justification of the beneficiary's current functional status and need for continued therapy, or any other information you think would help support your request for exception. You failed to submit a current plan of care.

This decision is not appealable. Medicare may not make payment for therapy services that exceed the current financial limitation. Such services are considered outside the scope of Medicare coverage, and the beneficiary may be charged (for the services) when an exception from the cap is not pre-approved. No advance beneficiary notice need be issued.

You may still submit a claim for these services expected to exceed the CAP, but you must not append the KX modifier to these services. If the service(s) exceed(s) the cap, the claim will be denied.

If the condition of the patient changes and additional therapy is now required, you may submit a new request.

For additional information, please see our Web site at www. ____.com

Sincerely,

[Insert Name and/or title]
Medical Review

Letter #4-Partial Approval

XXXX
XXXX
XXXX
Date

Submitter Name
Submitter Address
Case Number:
Beneficiary Name:
Medicare Number:

SUBJECT: Request for Exception from the Therapy Cap-Approved

Dear Sir/Madam

We have received your [X/XX/XXXX-Submission date] therapy cap exception request for the above named beneficiary. Based on the information submitted, we have determined that the beneficiary does meet the medical necessity requirements Medicare has established for granting an exception for a number of treatment days.
While the beneficiary does meet the medical necessity criteria for exception for a number of additional treatment days, we have determined that the beneficiary does not meet the medical necessity requirements for all of the days requested. We are approving exceptions to the cap for an additional [insert number of approved treatment days] treatment days subject to the terms and conditions below. This decision does not provide assurance that the beneficiary meets Medicare eligibility requirements nor does it assure that any other Medicare requirements (Medicare Secondary Payer, etc.) have been met. Only upon submission of a complete claim can [Contractor/Payer] make a full and complete determination.

To ensure proper processing of the claim for these approved services append the KX modifier to all of your applicable claim lines or it will deny. Do not append the modifier to claim lines not excepted by this letter or to services which are no longer medically necessary.

Also, this decision does not extend to the price Medicare will allow for the service(s). Payment amounts are determined upon receipt of the claim.

With respect to the requested days we could not approve, we have determined that the beneficiary does not meet the medical necessity requirements Medicare has established for granting an exception for these services for the following reasons:

Example: All requests for information must include information which documents the medical condition of the patient that necessitates additional therapy treatment days that will cause a beneficiary to exceed the cap. In our judgment, the documentation you provided is insufficient to support granting an exception.

This decision cannot be appealed. Medicare may not make payment for therapy services that exceed the current financial limitation. Such services are considered outside the scope of Medicare coverage, and the beneficiary may be charged for the services when an exception from the cap is not pre-approved. No advance beneficiary notice need be issued.

You may still submit a claim for these unapproved services expected to exceed the cap, but you must not append the KX modifier to these services. If the service(s) exceed(s) the cap, the claim will be denied. If the condition of the patient changes and additional therapy is required, you may submit a new request.

This therapy exception decision is valid for only [insert number approved] additional treatment days over the cap. Beneficiaries who require therapy are subject to rapid changes in medical condition. These changes may obviate the need for a particular service because the beneficiary's condition either improved or deteriorated. For this reason, if the condition of the patient changes and additional therapy is no longer required, you should not use the KX modifier nor expect payment from Medicare for these services.

We reserve the right to review claims on a pre-or postpayment basis, and may deny claims and take appropriate action when our approval was made based on fraud, misrepresentation, or we discover you are engaged in a pattern of aberrant billing.

For additional information, please see our Web site atwww. .com
Sincerely,
[Insert Name and/or title-insert reviewer name]
Medical Review

Letter #5-Positive Decision-Prepayment Review (For Providers on Review Other Than Probe Review or 100% Prepayment Review)

XXXX
XXXX
XXXX

Date

Submitter Name
Submitter Address

Case Number:
Beneficiary Name:
Medicare Number:

SUBJECT: Request for Exception from the Therapy Cap

Dear Sir/Madam

We have received your [X/XX/XXXX] therapy cap exception request for the above named beneficiary. Based on the information submitted, we have determined that the beneficiary does meet the medical necessity requirements Medicare has established for granting an exception for a number of treatment days. We are granting exceptions to the cap for an additional [insert number] treatment days subject to the terms and conditions below.

This decision does not provide assurance that the beneficiary meets Medicare eligibility requirements nor does it assure that any other Medicare requirements (Medicare

Secondary Payer, etc.) have been met. Only upon submission of a complete claim can the [Fiscal Intermediary/Payer] make a full and complete determination.

To ensure proper processing of the claim for these services, append the KX modifier to all your applicable claim lines or it will deny. Do not append the modifier to claims not excepted by this letter or to services which are no longer medically necessary.

Also, this decision does not extend to the price Medicare will allow for the service(s). Payment amounts are determined upon receipt of the claim.

This therapy exception decision is valid for [XX] additional treatment days over the cap. Beneficiaries who require therapy are subject to rapid changes in medical condition. These changes may obviate the need for a particular service because the beneficiary's condition either improved or deteriorated. For this reason, if the condition of the patient changes and additional therapy is no longer required, you should not use the KX modifier nor expect payment from Medicare for these services.

We reserve the right to review claims on a pre-or postpayment basis, and may deny claims and take appropriate action when our approval was made based on fraud, misrepresentation, or we discover you are engaged in a pattern of aberrant billing. This is particularly relevant in your case, since you have been placed on [Insert number and percentage] pre/postpay review.

For additional information, please see our website at www. ____.com

Sincerely,

[Insert Name and/or title]
Medical Review

Letter #6- For Providers on 100% Review

XXXX
XXXX
XXXX

Date

Submitter Name
Submitter Address

Case Number:
Beneficiary Name:

Medicare Number:

SUBJECT: Request for Exception from the Therapy Cap

Dear Sir/Madam

We have received your [X/XX/XXXX] therapy cap exception request for the above named beneficiary. You have a demonstrated pattern of potentially fraudulent, potentially abusive, or aberrant billing. Based on the limited information submitted with the request, we are granting an exception for [Insert number of] treatment days. However, if, based on the complete set of documentation you submit in response to an ADR, we determine that the service is not medically necessary, your claim may be denied.

This decision does not provide assurance that the beneficiary meets Medicare eligibility requirements nor does it assure that any other Medicare requirements (Medicare Secondary Payer, etc.) have been met. Only upon submission of a complete claim can the [Fiscal Intermediary/Payer] make a full and complete determination.

To ensure proper processing of the claim for these services, append the KX modifier to all your applicable claim lines or it will deny. Do not append the modifier to claims not excepted by this letter or to services which are no longer medically necessary.

Also, this decision does not extend to the price Medicare will allow for the service(s). Payment amounts are determined upon receipt of the claim.

This therapy exception decision is valid for [XX] additional treatment days over the cap. Beneficiaries who require therapy are subject to rapid changes in medical condition. These changes may obviate the need for a particular service because the beneficiary's condition either improved or deteriorated. For this reason, if the condition of the patient changes and additional therapy is no longer required, you should not use the KX modifier nor expect payment from Medicare for these services.

We reserve the right to review claims on a pre-or postpayment basis, and may deny claims and take appropriate action when our approval was made based on fraud, misrepresentation, or we discover you are engaged in a pattern of aberrant billing. This is particularly relevant in your case, since you have been placed on 100% pre/postpay review.

For additional information, please see our website at www. ____.com

Sincerely,

[Insert Name and/or title]
Medical Review

Tracking and Workload Reporting

The contractor shall develop a mechanism to track workload and costs associated with the Therapy Cap process and are to provide CMS with that information on a *monthly basis* to CMS_MRStrategies@cms.hhs.gov. The contractor shall also include the frequency of specific diagnoses that are being submitted for a manual exception. See chapter 11 for CAFM reporting requirements.

11.1.3.9 - Prepay Complex Review Workload and Cost (Activity Code 21221)

(Rev. 171; Issued: 11-09-06; Effective: 12-09-06; Implementation: 12-09-06)

Report all costs associated with prepay complex review in Activity Code 21221. In the workload section of CAFM II, Activity Code 21221, report the number of claims reviewed in Workload 1. Report the number of claims denied in whole or in part in Workload 2. Report the number of providers subject to prepay complex review in Workload 3.

The DMERCs shall report the number of Advanced Determinations of Medicare Coverage accepted (CMS IOM Pub.100-8, chapter.5, section 5.7) to miscellaneous code 21221/01.

The carriers and fiscal intermediaries shall report the therapy cap workload in activity code *27021*.